Home and Community Based Services
and the
Patient Protection and Affordable Care Act (PPACA) §2401 - 2406

Provision	Change Summary	Effective Date	Mandatory vs. Optional	Comments
§2401 Community First Choice Option	Codifies §1915(k) as a new option.	October 1, 2011 (PPACA says October 1, 2010 but the Reconciliation Act modified this date.)	Optional – States must submit 1915(k) SPA for approval.	Need to make decision re: whether NV should apply for a 1915(k) SPA.
	§1915(k)(1) State may provide for the provision of medical assistance for HCB attendant services and supports for eligible individuals whose income is <= 150% of the poverty line or the income level for institutional level of care under State Plan			
	§1915(k)(1)(A) State makes available HCB attendant services and supports for ADLs, IADLs, and health related tasks: • Under person centered plan based on functional assessment and agreed to in writing • In a home or community setting • Under agency provider model or other model which is selected and controlled by the recipient and • Provided by individual who is qualified to provide such services, including family members			

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	§1915(k)(1)(B) Includes acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health related tasks; backup systems or mechanisms; and voluntary training on how to select, manage, and dismiss attendants			
	§1915(k)(1)(C) Excludes room and board, services provided under IDEA or the Rehab Act, assistive technology devices and services, medical supplies and equipment, or home modifications			
	§1915(k)(1)(D) Permissible services include expenditures for transition costs and expenditures relating to an identified need in person centered plan that increases independence or substitutes for human assistance			
	§1915(k)(2) Up to 6% increased FFP for recipients served under this subsection.			
	States must: • Collaborate with a state-established Development and Implementation Council • Provide services statewide and in most integrated setting • Maintain or exceed preceding fiscal year level of state Medicaid expenditures for individuals with disabilities or elderly individuals • Establish and maintain comprehensive, continuous QA system			

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§2402 Removal of Barriers to Providing Home and Community Based Services	§ 2402(a) Secretary to promulgate regulations to ensure service systems designed to: • Allocate resources in manner responsive to changing needs/choices of recipients, maximizing independence, including use of client-employed providers • Provide support and coordination needed for recipient to design individualized, self-directed, community-supported life • Improve coordination among all providers to: ○ Achieve more consistent policy/procedures administration across programs ○ Oversee and monitor all service system functions	No date given for regulatory promulgation.		
	§2402(b)(6) Expansion of services that may be provided under 1915(i) by adding any service that could be approved under 1915(c) to the services that can now be covered under 1915(i) • Previous 1915(i) services were limited to those listed on 1915(c) and did not cover "such other services requested by the State as the Secretary may approve."	October 1, 2010 for all regulations modifying 1915(i).	Optional. Requires submission of 1915(i) SPA or amendment of existing 1915(i) SPA.	Removal of states' ability to cap the enrollment in 1915(i) programs may result in fiscal constraints in moving forward.
	Expansion of eligibility for 1915(i) to individuals whose income does not exceed 300% of SSI – enrollment may be phased in • Previous limit was to those whose income did not exceed 150% of FPL			
	New Medicaid eligibility group specific to 1915(i) - similar to 1915(c) eligibility group			

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	Waiver of comparability for institutional level group			
	Ability to target services			
	No enrollment cap allowed			
	No waiver of statewideness allowed			
§2403 Changes to Money Follows the Person Rebalancing Demonstration Grants	• Extends the end date from 2011 to 2016. • Reduces the period of time for which an eligible recipient must have resided in an institution from six months to 90 days. • Allows states that currently spend less than 50% of LTC services on non-institutional care to receive additional federal match.	April 23, 2010. Balancing incentive period begins October 1, 2011 and ends on September 30, 2015.	Optional. Requires grant application.	
	Secretary will provide definitions of institutionally-based and non-institutionally – based long term services and supports • Institutionally-based may include NF, ICF/MR • Non-institutionally based may include HCBS 1915(c) waivers, home health, personal care, PACE, self-directed personal assistance services under 1915(j).			
	States must apply to participate, agreeing to make structural changes no later than 6 mos. after application date, including: • No wrong door implementation • Conflict free case management services • Core standardized assessment instruments for determining eligibility • Collect and submit certain data related to services/quality/outcomes			
	Required to meet certain target spending percentages for non-institutional services by end of FFY 2015.			

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	Cannot apply more restrictive eligibility standards than those in effect December 31, 2010.			
	FMAP increase of +5% for states meeting 25% target; +2% for all others – but only for expenditures for non-institutionally-based long term services and supports (defined).			
	States must agree to use the additional federal funds only for purposes of providing new or expanded non-institutionally based services and supports.			
§2404 Changes to Spousal Impoverishment Rules	Extends spousal impoverishment rules to HCB applicants for a five year period. • Application of spousal impoverishment rules will be mandatory rather than optional. • Spousal impoverishment rules will apply to individuals with spend-down requirements where previously CMS has interpreted the rules as not applying to medically needy or spend down in 209(b) states.	January 1, 2014	Mandatory. Will require MRRC waiver amendment (see comments) and cost analysis.	Mandatory All waivers use spousal post-eligibility rules except MRRC which uses regular post-eligibility rules. Second bullet is not applicable as Nevada is not a medically needy nor a 209(b) state.
§2405 Funding to Expand State Aging and Disability Resource Centers	Expands funding for each of FFY 2010 – 2014 (total amount $10M each year).	Begins FFY 2010 (October 1, 2009 – September 30, 2010.	Optional.	ADSD may be interested.

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Sense of the Congress	"Address long term services and supports in a comprehensive way that guarantees elderly and disabled individuals the care they need" and that "long term services and supports should be made available to the community in addition to in institutions."			